DEPARTMENT OF HEALTH AND HUMAN SERVICES	
CENTERS FOR MEDICARE & MEDICAID SERVICES	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	01	COMPL	ETED		
		155491	B. WIN			09/20/2011			
			B. WII.		ADDRESS, CITY, STATE, ZIP CODE				
NAME OF P	PROVIDER OR SUPPLIER				AST 5TH STREET				
LINCOLN	CENTERS FOR R	EHABILITATION AND HEALTHCA	RE		ERSVILLE, IN47331				
(X4) ID	SUMMARY S	SUMMARY STATEMENT OF DEFICIENCIES		SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE		
K0000									
	A Life Safety Code Recertification and		K(0000	Preparation or execution of this	plan			
	State Licensure S	Survey was conducted by			of correction (POC) does				
		Department of Health in			not constitute an admission or a	ssent			
		42 CFR 483.70(a).			by the provider to the truth,				
	accordance with	72 CTR 403./0(a).			accuracy or veracity of the facts				
		4044		alleged or conclusions set forth					
	Survey Date: 09	/19/11 and 09/20/11			in the Statement of Deficiencies				
					(SOD). The POC is prepared an executed solely because it is rec				
	Facility Number:	000316			under	lunea			
	Provider Number	r: 155491			law.				
	AIM Number: 100286370				iaw.				
	THINT I (dillo ci. I	00200370			By this response, Lincoln Cente	ers			
	C Maul-	Darami Life Cofety Code			Rehab acknowledges				
	Surveyor: Mark Bugni, Life Safety Code Specialist				receipt of the SOD and alleges	hat it			
					is in compliance.				
					Accordingly, the POC is submit	tted			
	At this Life Safet	ty Code survey, Lincoln			as alleged compliance				
	Centers for Rehabilitation and Healthcare was found not in compliance with Requirements for Participation in				as of October 20, 2011.				
	*	•							
	Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the								
	2000 edition of the								
		iation (NFPA) 101, Life							
	Safety Code (LS)	C), Chapter 19, Existing							
	Health Care Occi	upancies and 410 IAC							
	16.2.								
	The facility cons	ists of two separate							
	buildings. The E	•							
		777 and is a one story							
		V (111) construction.							
	The West buildin	g was constructed in							
	1971 and is a one	e story building of Type V							
					L				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

DX6G21

Facility ID:

000316

If continuation sheet

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155491	A. BUI	LDING	onstruction 01	(X3) DATE S COMPL 09/20/2	ETED
NAME OF B	DOWNER OF CURRINE		B. WIN		ADDRESS, CITY, STATE, ZIP CODE	09/20/2	011
	ROVIDER OR SUPPLIER	EHABILITATION AND HEALTHO	ΔRF	1	AST 5TH STREET ERSVILLE, IN47331		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID			(X5)
PREFIX TAG	,	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
	(EACH DEFICIENCE REGULATORY OR (111) construction buildings are the construction, the one building. Both buildings are complete sprinkle facility has a fire smoke detection open to the corries smoke detection. Hall resident room The facility has a a census of 106 at Quality Review by F. Code Specialist-Medium Code Spe	n. Because both same type of facility was surveyed as re provided with er protection. The alarm system with in the corridors, spaces dors, and single station in the 300 Hall and 400 ms in the East building. It capacity of 152 and had at the time of this survey. Robert Booher, Life Safety dical Surveyor on 09/22/11.			CROSS-REFERENCED TO THE APPROPRIA	TE	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 01 A. BUILDING 155491 09/20/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1029 EAST 5TH STREET LINCOLN CENTERS FOR REHABILITATION AND HEALTHCARE CONNERSVILLE, IN47331 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE One hour fire rated construction (with 3/4 hour K0029 fire-rated doors) or an approved automatic fire SS=E extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 K 029: It is the policy of this facility Based on observation and interview, the K0029 10/20/2011 to comply with K 029 facility failed to ensure the corridor doors to 3 of 12 hazardous areas in the West Self door closures will be installed in building, such as combustible storage all storage rooms over 50ft on 600 rooms over 50 square feet in size, were hall All storage rooms over 50 ft on all other halls checked to ensure provided with self closing devices which appropriate self door closures were would cause the doors to automatically in place close and latch into the door frames. This deficient practice could affect any Maintenance Director reeducated to residents who use the beauty shop and ensure all self door closures are installed for all storage rooms over main dining room, which was located in 50 ft. the West building 600 Hall where no resident rooms are located. Maintenance Director or designee will complete a QA check Findings include: all for self closing doors in storage rooms monthly x 4 weeks and then Based on observation on 09/19/11 at 1:00 quarterly p.m. with the maintenance supervisor, the thereafter. Results of this QA two 600 Hall storage rooms and the 600 review will be reviewed at the Hall file storage room in the West QI/QA meeting. building, located across from the maintenance supervisor's office, each Correction date: 10/20/11 measured one hundred sixty square feet in size, stored shelves of combustible paper,

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Event ID:

DX6G21 Facility ID:

000316

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA ((X2) MI	JLTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		IDENTIFICATION NUMBER:	A. BUII	DING	01	COMPL	ETED
		155491	B. WIN			09/20/2	011
NAME OF D	DOMBER OF GUIDNI IED				ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			1029 E	AST 5TH STREET		
LINCOLN	LINCOLN CENTERS FOR REHABILITATION AND HEALTHCAI			CONNE	ERSVILLE, IN47331		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		CRO		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Έ	COMPLETION
TAG		· · · · · · · · · · · · · · · · · · ·		TAG	DEFICIENCY		DATE
		of adult briefs, plastic					
	mattresses, and cardboard boxes of paper, and were not provided with self closing						
		oors. This was verified					
	•	ice supervisor at the time					
		nd confirmed by the					
		the exit conference on					
	09/20/11 at 1:00	p.m.					
	3.1-19(b)						
K0038 SS=E	readily accessible with section 7.1.			0038	K 038: It is the policy of this		10/20/2011
					facility to comply with K		10/20/2011
		ewalk surface on 1			038 Maintenance will repair of		
		walks in the West			replace sidewalk outside of 9	00	
		naintained to			hall to ensure appropriate elevation levels. Maintenance will		
	_			check all entrances and exits on all halls to ensure appropriate elevation levels Maintenance			
	=	revent elevation changes. LSC 1.6.2 requires abrupt changes in					
	=						
		e walking surface			Director or designee will complete a QA check all sidewalk		
		shall not exceed 1/4 inch. Changes in elevation exceeding			entrances and exits once mo	nthly	
					x 4 weeks and then quarterly		
		ot exceeding 1/2			thereafter. Results of this Q/ review will be reviewed at the		
	inch shall be be				QI/QA meeting. Correction da		
	•	vation exceeding			10/20/11		
	•	oe considered a					
	change in level						
	-	requirements of					
	7.1.7. This def	icient practice					
	affects 22 resid	lents who reside on					
	the 900 Hall in	the West building.					
!							

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000316

If continuation sheet

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED 09/20/2011	
AND PLAN	A. BUILDING		01				
		155491	B. WING			09/20/2	011
NAME OF I	PROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP CODE		
LINCOLN	I CENTERS FOR R	EHABILITATION AND HEALTHCA	RF		AST 5TH STREET ERSVILLE, IN47331		
	SUMMARY STATEMENT OF DEFICIENCIES				INOVIELE, IIVII 00 I		(27.5)
(X4) ID PREFIX		CY MUST BE PERCEDED BY FULL	F	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	*	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	DATE
	Findings includ	le:					
	J						
	Based on obser	vation with the					
	maintenance supervisor on						
		1:55 a.m., the West					
		all north sidewalk					
	discharged fror	ท the exit door					
	onto a concrete	e sidewalk					
	extending sixty	/ four feet to the					
	parking lot. Th	ne interconnected					
	section of side	walk in front of the					
	storage garage	, which measured					
	twelve feet by t	en feet had four					
	sections of con	crete broken and					
	heaving with or	ne inch changes in					
	the sidewalk el	evation. Based on					
	an interview wi	th the maintenance					
	supervisor on 09/19/11 at 12:10						
	p.m., the concr	ete sidewalk					
	surface in front	t of the storage					
	garage broke o	ver the past winter					
	and began to h	eave. This was					
	confirmed by th	he administrator at					
	the exit confere	ence on 09/20/11					
	at 1:00 p.m.						
	3.1-19(b)						
K0144 SS=F		spected weekly and oad for 30 minutes per nce with NFPA 99.					
	Based on record	review and interview, the ensure the fuel source for	K0	144	K 144: It is the policy of this fato comply with K 144	cility	10/20/2011

				ULTIPLE CO	NSTRUCTION	(X3) DATE S COMPL	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155491	A. BUI	LDING	01	09/20/2	
		155491	B. WIN		PRESIDENT OF THE CORP.	09/20/2	
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE AST 5TH STREET		
LINCOLN	N CENTERS FOR R	EHABILITATION AND HEALTHC	ARE	1	ERSVILLE, IN47331		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		1	ID			(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	-	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	1 of 1 emergency	generators for the West					
	building was from	n a reliable source.			Maintenance will contact a loca		
	NFPA 110, 1999	Edition, Standard for			propane distributor to install pro tank to ensure emergency gener	-	
	Emergency and S	Standby Power Systems,			fuel source is continually maint		
	Chapter 3, Emerg	gency Power Supply			Maintenance Director or design	ee	
	(EPS), 3-1.1, End	ergy Sources states the			will complete a QA check to en		
	following energy				proper fuels are maintained onc weekly. Results of this QA revi		
	permitted for use	for the emergency power			will be reviewed at the QI/QA	iew	
	supply (EPS):				meeting.		
	a) Liquid Petrolo	•					
	atmospheric pres				Correction date: 10/20/11		
		roleum gas (liquid or					
	vapor withdrawa	1)					
	c) Natural or syr	nthetic gas					
	Exception: For I	Level 1 installations in					
	locations where t	the probability of					
	interruption of of	ffsite fuel supplies is					
		earthquake, flood					
	damage or demon	-					
	3 //	-site storage of an					
	alternate energy	source sufficient to allow					
	•	emergency power supply					
		be delivered for the					
	*	nall be required, with					
	•	omatic transfer from the					
		ource to the alternate					
	energy source.						
	CMS (Centers fo	or					
	Medicare/Medi	caid Services)					
	requires a lette	r of reliability from					
	the natural gas	vendor regarding					
	the fuel supply	that must contain					
	the following:						

AND PLAN OF CORRECTION IDENTIFICATION NUMBER		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IULTIPLE CO LDING	INSTRUCTION 01	(X3) DATE SURVEY COMPLETED	
		155491	B. WIN	IG		09/20/2011	
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
LINCOLN	I CENTEDS EOD D	EHABILITATION AND HEALTHO	\ADE	1	AST 5TH STREET ERSVILLE, IN47331		
	SUMMARY STATEMENT OF DEFICIENCIES			<u> </u>	INOVILLE, INTIONI	1 (75)	
(X4) ID PREFIX		CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETIO)N
TAG	*	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	,,,
	1. A statement	of reasonable					
	reliability of the natural gas						
	delivery.	-					
	2. A brief desc	ription that					
	supports the st	atement regarding					
	the reliability.						
	3. A statement	that there is a low					
	probability of i	nterruption of the					
	natural gas.						
	4. A brief desc	ription that					
		atement regarding					
		ility of interruption,					
	_	re of a technical					
	person from th	e natural gas					
	provider.						
	-	actice affects all residents					
	in the West build	ing.					
	Findings include	:					
	Based on an inter	rview with the					
	maintenance sup	ervisor on 09/19/11 at the					
	10:50 a.m. review	w of the Emergency					
	Generator Weekl	y and Monthly Log					
	Sheets, the fuel s	ource for the West					
		ncy generator was natural					
	gas. Based on an interview with the						
	-	ervisor on 09/19/11 at					
		acility does not have a					
		ntural gas provider stating					
		ce for the generator is a					
		This was confirmed by					
	uie auministrator	at the exit conference on					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		ON IDENTIFICATION NUMBER:		CONSTRUCTION 01	(X3) DATE SURVEY COMPLETED	
THIBTEAU	or condition	155/01	A. BUILDING B. WING		09/20/2011	
				ET ADDRESS, CITY, STATE, ZIP CODE		
	PROVIDER OR SUPPLIER			EAST 5TH STREET		
LINCOLN	I CENTERS FOR R	EHABILITATION AND HEALTHCA	RE CON	NERSVILLE, IN47331		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E COMPLETION DATE	
IAG	09/20/11 at 1:00		IAG		DAIL	_
	05/20/11 at 1.00	p.m.				
	3.1-19(b)					
	、 /					